VARICELLA (HOSPITALIZED) CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 49943 (R/7-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** ___ - ___ - ___

Number & Street Address

City **State** **ZIP Code** ___ - ___

County **Date of Birth** ___ / ___ / ___ **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Section 2. Clinical Information

Hospital Name

Diagnosing Physician Name

Diagnosing Physician Phone ___ - ___ - ___

Family Physician Name

Family Physician Phone ___ - ___ - ___

Date of Rash Onset ___ / ___ / ___ **Admission Date** ___ / ___ / ___ **Discharge Date** ___ / ___ / ___

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Section 2. Clinical Information (continued)

Complications (Check all that apply):

- O Secondary Infection:
  - **Bacterial Species**
  - O From Strep Species: _____
  - O From Staph Species: _____
  - O Other - Name Organism: _____
  - **Type of Infection:**
    - O Skin/Soft Tissue
    - O Sepsis/Septicemia
    - O Necrotizing Fasciitis
    - O Toxic Shock Syndrome
    - O Bone/Joint Infection
    - O Other
- O Pneumonia/Pneumonitis
- O Neurologic Complication
- O Congenital Varicella Syndrome
- O Reye Syndrome
- O Other, specify: _____
- O None

Pre-existing Medical Conditions:

- O None
- O Cancer
  - **Type:** _____
- O Transplant Recipient
  - **Organ:** _____
- O Immune Deficiency
  - **Type:** _____
- O HIV/AIDS
- O Pregnancy
  - **If pregnant, number of weeks:** ____
- O Premature Infant
  - **Gestational age:** ____ **weeks**
  - **Birth weight:** ____ **grams**
- O Other Condition, specify: _____
- O Unknown

Source of Infection

- O Parent
- O Son
- O Daughter
- O Other Family Member
- O Other, specify: _____

Outcome:

O Survived O Died O Unknown

Vaccination Data (Provide dates of all doses given *prior* to illness)

1. ____ / ____ / ____
   Date Given

   _____ **Manufacturer** _____ **Lot Number**

2. ____ / ____ / ____
   Date Given

   _____ **Manufacturer** _____ **Lot Number**

Number of doses received on or after first birthday? ____

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Section 3. Laboratory Information - Testing is Optional (Collect only if available)

Was laboratory testing for Varicella done?

O Yes O No O Unknown

1. IgM Testing

__/__/__
Date IgM specimen taken

Results:
- O Positive
- O Negative
- O Indeterminate
- O Pending
- O Not Done
- O Unknown

2. IgG Testing

__/__/__
Date Acute Specimen Taken

Acute Value

__/__/__
Date Convalescent Specimen Taken

Convalescent Value

Results:
- O Significant Rise in IgG
- O No Significant Rise in IgG
- O Pending
- O Not Done
- O Indeterminate
- O Unknown

3. Other Testing

__/__/__
Date Other Lab Result

Specify Other Lab Method

Results:
- O Positive
- O Negative
- O Indeterminate
- O Pending
- O Not Done
- O Unknown

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number ___-___-____

Date __/__/__

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3